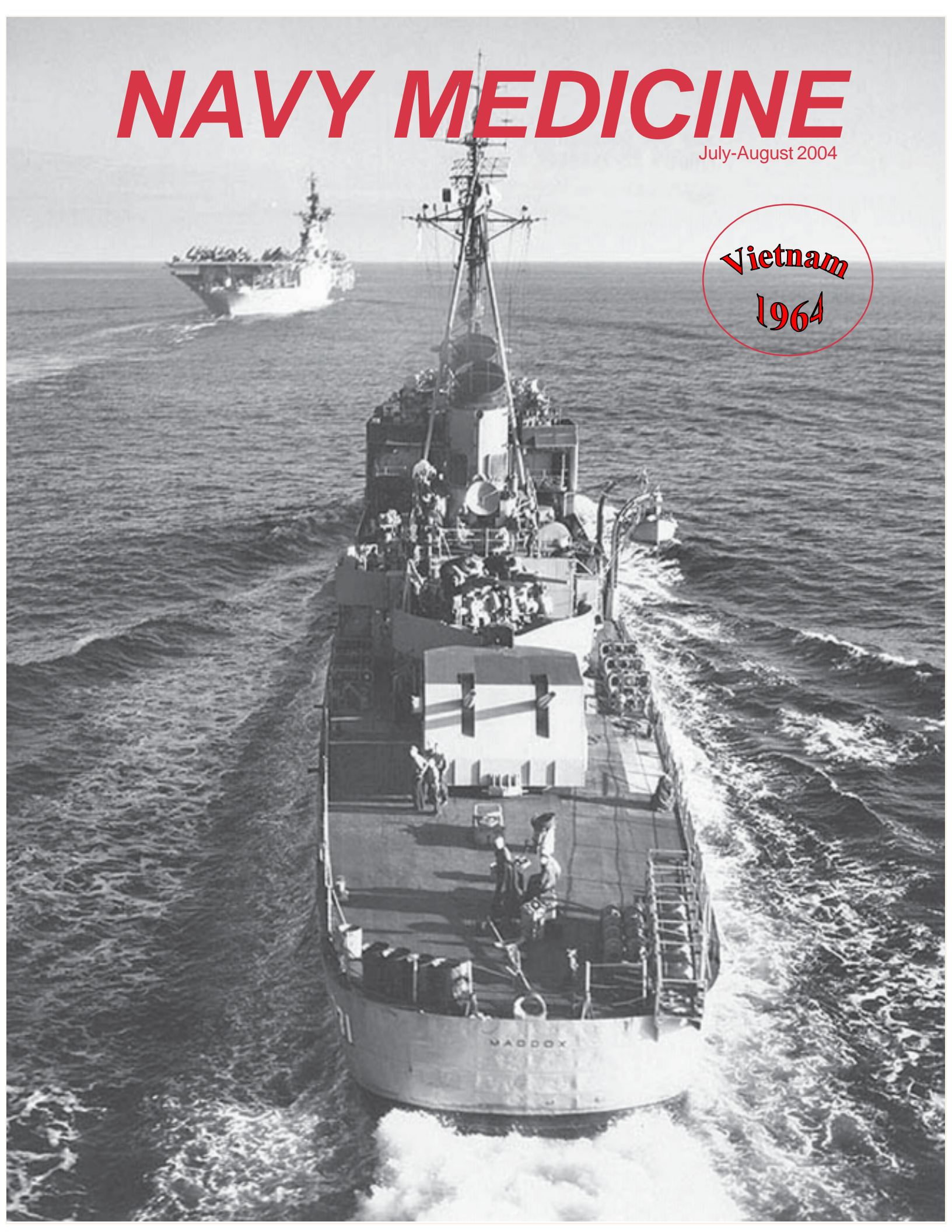


NAVY MEDICINE

July-August 2004

Vietnam
1964



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NAVY MEDICINE, Vol. 95, No. 4 (ISSN 0895-8211 USPS 316-070) is published bimonthly by the Department of the Navy, Bureau of Medicine and Surgery (M00H), Washington, DC 20372-5300. Periodical postage paid at Washington, DC.

POSTMASTER: Send address changes to Assistant Editor, *Navy Medicine*, Bureau of Medicine and Surgery, ATTN: M00H, 2300 E Street NW, Washington, DC 20372-5300.

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NAVY MEDICINE is published from appropriated funds by authority of the Bureau of Medicine and Surgery in accordance with Navy Publications and Printing Regulations P-35. The Secretary of the Navy has determined that this publication is necessary in the transaction of business required by law of the Department of the Navy. Funds for printing this publication have been approved by the Navy Publications and Printing Policy Committee. Articles, letters, and address changes may be forwarded to the Assistant Editor, *Navy Medicine*, Bureau of Medicine and Surgery, ATTN: M00H, 2300 E Street NW, Washington, DC 20372-5300. Telephone (Area Code 202) 762-3248/46; DSN 762-3248/46, jmhores@us.med.navy.mil. Contributions from the field are welcome and will be published as space permits, subject to editing and possible abridgment.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington DC 20402.

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COVER: Forty years ago North Vietnamese torpedo boats attacked USS *Maddox* (DD-731) in the Gulf of Tonkin. The congressional resolution that followed assured escalation of the war in Southeast Asia. Story on page 23. Photo courtesy of the Naval Historical Center.

Changes in Operational Dental Readiness Standards Available on CD-ROM

LCDR Michael C. Bilak, MSC, USN

A revised CD detailing changes in the dental classification system was mailed to over 1,100 dental officers and civilian dentists who provide dental care on 60 ships and in 15 dental centers around the world. The CD, referred to as the Dental Image Quiz, was updated by a team of researchers from the Naval Institute for Dental and Biomedical Research (NIDBR), in collaboration with the University of Texas Health Sciences Center. The team designed the original CD in 1995.

"This CD has a proven track record as an invaluable aid in training dental officers in the categorization of dental treatment needs based on DOD requirements," said CAPT James C. Ragain, Jr., NIDBR commanding officer. "The updated CD features more than 35 clinical cases to test a dental officer's understanding of diagnostic classification in the areas of operative dentistry, oral surgery, endodontics, periodontics, prosthodontics, orthodontics, oral medicine, and temporomandibular disorders."

Each clinical case is presented in a question and answer format with clinical photographs and radiographic images, as appropriate, augmenting the case descriptions.

"The Dental Image Quiz CD-ROM clarifies the complexities of the dental classification system by providing clinical examples, as well as rationale for the classification assignments," said CAPT K.E. Diefenderfer, project coordinator and NIDBR special assistant for operational research. "This is an invaluable resource for recalibrating our active and Reserve dental officers and for initial training of new dental officers as they begin active duty."

Also available on the CD is the Navy Dental Corps' oral disease risk management and specialty specific treatment guidelines to provide clinicians with a completed reference background.

Unlike civilian populations, the Navy and Marine Corps have established mission requirements for operational dental readiness. The frequently

hostile working conditions and challenging duty assignments faced by Sailors and Marines have significant implications on their dental health and readiness. Navy dentistry utilizes a Dental Classification System to prioritize dental treatment and to identify an individual Sailor or Marine's operational dental readiness.

For over 50 years, researchers at NIDBR have investigated problems related to oral health, disease, and injury and developed techniques and products to improve dental and medical care in the Navy. With the co-location of the Army Dental Research Detachment (1996) and the U.S. Air Force Dental Investigation Service (2000), the Institute is the site for all DOD dental research. □

LCDR Bilak is Head, Resource Management Department, NIDBR, Great Lakes, IL.

Naval Hospital Beaufort

Reflections on a Mass Casualty

CDR Patricia M. Binns, NC, USN (Ret.)

There's been a bad accident." These words quickly made their way around to all the people gathered in small clusters at the National Cemetery in Beaufort, SC, shortly after 0800 on Friday, 12 March 2004.

As Public Affairs Officer at Naval Hospital Beaufort (NHB), I was at the cemetery on this beautiful March morning to participate in a memorial service. The crew of USS *William Pinckney* (DDG-91), was about to begin a service to honor their ship's namesake and his widow, Henrietta, a resident of Beaufort. The senior officers and three busloads of the crew had already made their way down from Charleston and were mingling with members of the Pinckney family and friends. The ceremony was slated to begin at 0800 and the Honor Guard and rifle bearers were getting in a final practice as the crowd awaited the arrival of two more busloads of the ship's Sailors.

For approximately 10 minutes, sirens had been heard in the background and all of us anxiously wondered where the ambulances and rescue crews were headed. Shortly after 0800, the word of an accident was received and the news was indeed tragic. The remaining two buses of Sailors had been involved in a head-on collision with a truck, about 20 miles away from the cemetery. LT Erskine Alvis, a chaplain from NHB

who was attending the ceremony to deliver the invocation and benediction, told the Pinckney family and friends of the accident and they formed a prayer circle in response. CDR Byron, the ship's commanding officer, gathered his crew and told them what had happened to their shipmates. The decision was made to go ahead with the memorial service, though it would now take on an even more somber tone than originally planned.

We now began to receive reports concerning the severity of the accident and the types of injuries sustained. It quickly became clear that rescue crews from all over Beaufort County were responding to transport the most critically injured to trauma centers in Beaufort, Savannah, and Charleston. It was also confirmed that there had been three fatalities, including the military driver of one of the buses.

As more details became available, it was decided that the executive officer of the ship would return to Charleston with a majority of the crew. The commanding officer, command master chief, and the ship's public affairs officer would embark on a trip to visit their injured crew members at all the involved hospitals before returning to Charleston. Their first stop was Beaufort Memorial Hospital, where the group spent a few minutes visiting Sailors before moving onto NHB.

Emergency Operations Center

NHB had been informed that around 40 Sailors would be arriving for evaluation and treatment. The staff quickly implemented their Mass Casualty Plan, with providers, nurses, and corpsmen setting up the stations for which they had so often trained. In Emergency Operation Center (EOC), LCDR Patricia Chapple, NHB's Command Emergency Manager, feverishly manned the phones with Commander Navy Region Southeast (CNRSE), Fleet Forces Command (FFC), and the National Safety Transportation Board, receiving and dispensing information as it became available.

Working with her in EOC, Patient Administration staff assisted in patient tracking, including getting the latest accurate information about casualties. "Initial information was unclear about how many buses were involved; whether Marines or Sailors were onboard; and what area hospitals were receiving victims," said Chapple. According to her, clear communication was the greatest challenge among all the involved agencies. Chapple also felt that staff displayed extraordinary adaptability. As news of the numbers and types of casualties became clearer, the decision was made to change the site of primary triage. The new site worked exceedingly well and accommodated traffic flow much more efficiently. She attributes this to



Medevac helicopter takes off from the crash site transporting a critically injured patient to a local trauma center.

the many hours of mass casualty drilling that enabled staff to “think on their feet.”

Triage

HM3 Michael Ponder, NHB’s EMS Supervisor, was teaching an EMT class when he heard of the accident over his radio. He immediately released two students from Crash, Fire, and Rescue to go to the scene. Along with his 18 students, he reported to the main hospital to await word of casualties. Ponder was able to hear the dispatcher for Beaufort County EMS, thereby keeping current on the progress at the scene by the Incident Commander (IC). Upon hearing that 37 casualties were expected at NHB, Ponder put out the call for ambulances and EMTs from Marine Corps Recruit Depot (MCRD), Parris Island. He then began staging and briefing response teams at the Primary Triage area, including litter bearers, recorders, and administrative staff. Medical teams were staged at Primary Triage and secondary stations throughout the hospital. Acting as a liaison with Beaufort Memorial Hospital, he relayed information to the EOC while awaiting the arrival of casualties at NHB.

This was Ponder’s first experience with a mass casualty since he joined the military. “I teach classes constantly on handling something like this, but I hoped that I’d never have to perform what I teach,” stated Ponder.

Spiritual Intervention

“I remember sounds, cell phones ringing, and loud sirens in the background,” related LT Erskine Alvis. Upon hearing word of the accident, Alvis said “I knew I needed to get other chaplains in the community involved very quickly.” The commanding officer of *Pinckney* requested that he pray with the crew. “My immediate concerns were with the crew, the ship’s leaders, the Pinckney family, and families of the Sailors,” said Alvis. Chaplains from local bases, on both coasts, including MCRD, Parris Island, Marine Corps Air Station, Beaufort, Charleston Naval Weapons Station, Naval Station San Diego, and the Air Force came together as a team, offering ministry and counseling.

Though this was his first experience with a mass casualty as a military chaplain, he was extremely gratified that the medical staff was open to and supportive of spiritual care. He also felt that there was excellent collaboration among bases, on both coasts, to get chaplains where they needed to be in an expeditious manner. “You never know when someone will walk up to you and say help,” noted Alvis.

Mental Health Intervention

“I was asked to accompany the *Pinckney*’s Sailors during her cruise from Charleston to Norfolk to provide mental health counseling,” said HM2 James Morrison, a psychiatric tech-

nician at NHB. During the 7-day journey, Morrison talked with many Sailors about their feelings before, during, and after the accident. “Many expressed a strong sense of guilt at not being able to prevent the accident or keep others alive,” said Morrison, “Others were experiencing problems eating and sleeping and some reported having nightmares.” Morrison worked closely with the independent duty corpsman and the chief community onboard to offer counseling to all those in need. “I didn’t really know that I would end up seeing so many people and I wish I could have stayed longer,” said Morrison of his challenging, but ultimately rewarding assignment.

For the majority of staff at NHB, this was the first time dealing with a mass casualty. The hospital’s commanding officer, CAPT J.R. Hoffower noted, “Although a tragic event, the NHB staff reacted in a remarkably poised and confident manner to address the needs of shipmates in extremis.” The entire event revealed the close associations between emergency response agencies from Beaufort County, local community, and tri-command personnel. The significant efforts that have been placed on drilling and reviewing lessons learned resulted in response efforts that were unparalleled. “This mass casualty had all the hallmarks of being much worse than it was,” Hoffower remarked, “What transpired was a true team effort” □

CDR Binns is Public Affairs Officer at Naval Hospital Beaufort, SC.

New Medical Department Flag Selections



CAPT Christine M. Bruzek-Kohler, NC, USN is Assistant Deputy Chief of BUMED, Medical Operations Support

CAPT Bruzek-Kohler attended Villanova University where she received a Bachelor of Science in Nursing and her commission as an ensign in 1974.

CAPT Bruzek-Kohler's assignments have included charge nurse, National Naval Medical Center, Bethesda, MD; staff nurse, U.S. Naval Regional Medical Center, Naples, Italy; Ambulatory Care Coordinator, Naval Hospital Newport, RI; Director of Academic Support Department, Naval School of Health Sciences, Bethesda, MD; Head of Enlisted Training Programs, Naval Health Sciences Education and Training Command; Director of Nursing, U.S. Naval Hospital, Guam; Executive Officer, Naval Hospital, Pensacola, FL; and

Commanding Officer, Naval Hospital, Lemoore, CA.

Her military awards include the Legion of Merit, Meritorious Service Medal with one Gold Star, Navy and Marine Corps Commendation Medal with one Gold Star, and Navy and Marine Corps Achievement Medal with one Gold Star.

CAPT Bruzek-Kohler also holds a Masters of Education degree from Providence College, and a Master of Arts, and a Doctor of Education from George Washington University. □

* * * * *



CAPT Christine S. Hunter, MC, USN is U.S. Pacific Fleet Surgeon

CAPT Hunter completed both undergraduate and medical studies at Boston University,

and was awarded her Bachelor of Arts and Doctor of Medicine Degrees with honors in 1980. Dr. Hunter served her internship at Boston University Medical Center.

Following her internship Dr. Hunter served as Senior Medical Officer aboard USS *Hunley* (AS-31) in Holy Loch, Scotland. In 1983 she reported to Naval Medical Center San Diego for her residency in Internal Medicine and Fellowship in Hematology/Oncology. She is board certified in all three fields.

Dr. Hunter's assignments have included Assistant Chairman of Internal Medicine, Assistant Program Director for the Internal Medicine Residency Program, and Director, Medical Services at Naval Medical Center San Diego; Executive Assistant to the Navy Surgeon General from 1998 until 2000; and Commanding Officer, Naval Hospital Bremerton.

CAPT Hunter's personal decorations include the Legion of Merit (three awards), Defense Meritorious Service Medal, Meritorious Service Medal, Navy and Marine Corps Commendation Medal (two awards), and Navy and Marine Corps Achievement Medal (two awards).

CAPT Hunter is a Fellow of the American College of Physicians (ACP) and holds membership in the American Societies of Hematology and Clinical Oncology. She has also served as chairperson of the national ACP Postgraduate Education Subcommittee. □

Features

Surgeon General Dedicates Center for Naval Operational Medical Lessons Learned

Ed Brown

During a ceremony on 14 April 2004, VADM Michael L. Cowan, Surgeon General of the Navy, dedicated the Naval Operational Medicine Institute (NOMI) Naval Operational Medical Lessons Learned Center (NOMLLC) aboard Naval Air Station Pensacola, FL.

CAPT Douglas H. Freer, MC, NOMI commanding officer, has led the development of a dedicated Naval Operational Medical Lessons Learned Center that progressed from concept to reality in June 2003. The web-based system increases the capture of information, observations, and issues from naval medical personnel in the operational forces and provides input that augments the official service-owned program for lessons learned collection. The NOMI center has recently been accepted by the Navy as a satellite of the official Navy Lessons Learned System (NLLS).

Based on recent experience in operational medicine, NOMI recognized that Fleet and Fleet Marine Force medical lessons learned submitted to the NLLS and the parallel Marine Corps Lessons Learned System (MCLLS) were difficult to separate from larger warfighter issues. Medical lessons learned frequently became lessons lost. The concept of creating the lessons learned system specific to health service support while sustaining NLLS and MCLLS was proposed and accepted by the Surgeon General of the Navy. On 4 April 2003, NOMI was designated as the central repository for Navy medical lessons learned.

The success of force health protection efforts requires constant information and feedback from the operational forces in order to identify threats and issues faced by deployed forces and to evaluate the effectiveness of current in-place efforts and countermeasures. Having hosted two conferences of invited personnel who participated in Operation Enduring Freedom and Operation Iraqi Freedom, NOMI has collected more than 500 observations

from the field. To date, 350 of those observations have been vetted by subject matter experts throughout the Fleet and Fleet Marine Forces and have led to the submission of more than 40 issues into the Health Services Support Combat Development Process.

The collection, collation, trend tracking, and recognition of issues, problems, recommendations, and potential solutions are now being captured for Navy medicine by the NOMLLC. To enhance access to the NOMLLC system and provide a worldwide forum for designated subject matter experts to review and validate submitted observations, a specific Navy Knowledge Online portal was opened in December 2003.

The Naval Operational Medical Lessons Learned system's website is: <https://mll.nomi.med.navy.mil/>. □

Mr. Edwards is Subject Matter Expert for the Naval Operational Medical Lessons Learned Center, Naval Operational Medicine Institute, Pensacola, FL.



VADM Cowan, Surgeon General of the Navy and CAPT Freer, CO, NOMI, cut the ribbon dedicating the Naval Operational Medical Lessons Learned Center.

Photo by Gary Nichols, NAS Pensacola GOSPORT staff photographer

Stress of Caring for Combat Casualties

RADM Frances T. Shea Buckley, NC, USN (Ret.)

The following is a speech given by RADM Shea Buckley at the 89th Annual Meeting of AMSUS (Association of Military Surgeons of the United States) in Orlando, FL, 17-21 October 1982 and is reprinted from U.S. Navy Medicine, January-February 1983.

A friend of mine is a professional speech writer for the Bell Telephone Company. In addition, he prepares seminars for the service academies and industry on how to present successfully. According to him, an in-depth knowledge of the audience is of prime importance. For this group, that is not possible. While there is a commonality in that we are all members of the Federal service medical departments, our experiences and backgrounds are different. Some of you relate to and understand intimately the stress I am about to discuss; others will have difficulty identifying with it. In sharing my thoughts and experiences with you, it is my hope that you never have to experience the stress of caring for combat casualties. But if you do, you might remember that you are not alone.

My presentation is based on personal, not scientific data. I can only tell you how the stress of caring for casualties in a combat situation affected me. I can also say that in recent years, while exchanging ideas

with other Nurse Corps officers having served in Vietnam, I found that our experiences and feelings were quite similar. As a result, we did identify and react to stress in the post-Vietnam years. Although there is an attempt at present to obtain scientific data concerning stress among nurse Vietnam veterans, nothing has yet been published.

Let me say at the outset that I did what I had to do in order to survive emotionally and physically. One adjusts to the initial shock of caring for casualties within a few days or so. Although I had been an operating room nurse with a background in trauma surgery, I was not prepared for the catastrophic casualties that would come to my operating room. My initial feelings were shock, disbelief, hurt, and anger. But, as I said, I quickly adjusted to the fact that the casualties were there and had to be cared for in the best and most efficient manner.

As an operating room supervisor and nurse, I made preoperative visits to all patients in the preanesthesia staging area. I told them they were safe, in a clean environment, and would be cared for soon. I encouraged them to tell me what had happened to them. It was considered to be good psychologically to let the patient debrief as rapidly as possible. They would tell me how they were

ambushed, hit, or tripped a mine. I had no difficulty in this phase of their intraoperative care.

During the 13 months, I remember crying once and, even then, that young man was not seriously injured. However, for all the calm exteriors, there were patients I can describe to you in most vivid detail even today. One of my nurse friends refers to them as the "patients that got to you."

- The gunnery sergeant, who after his 15th visit to the operating room, finally died. He was the one I told on admission, "Hey Sarge, you are going to make it—it's going to be okay." I was wrong. I never told another casualty he'd make it.

- The 19-year-old who took a direct hit to the scrotum and, with his testicles laying on the gurney, asked me, "Nurse, will I be able to have children?" and, I callously said, "You can always adopt."

- The hemicorporectomy who died as soon as we got him off the table.

- The many Marines whose story was always the same: "Nurse, take care of my buddy first."

I could handle the preoperative and operative phase of caring for the patient deliberately, calmly, and unemotionally. What I could not do was visit the patient postoperatively; it was simply too difficult.

Now, I felt guilty about this because if I was a good operating room nurse

I should have been able to provide total care. I did not discuss my feelings concerning the patients with anyone on the ship, nor did any nurse discuss her feelings with me. It was as if we led two lives—our working hours caring for casualties and our nonworking hours. The conversations were light and innocuous. We talked about Subic, R & R, or whatever hobbies we might have. We were confined to the ship except for very rare occasions when we might go ashore to Danang for a cold beer and a bowl of chili.

When my tour was up and I returned stateside, I have to tell you that I felt guilty—guilty I didn't do enough, didn't care enough, guilty I left my shipmates and patients behind. This was not an unusual reaction. Many of us experienced similar feelings. My initial return to a naval hospital left something to be desired. Although I welcomed the routine cholecystectomy, I was impatient with the slower-paced running of the schedule, apparent waste of time, the long turnover periods between cases and nonemergent emergencies. I had difficulty hiding annoyance at surgeons who appeared to perform at a lower level of productivity and dedication than those physicians with whom I worked in Vietnam. Eventually, I left the operating room to become an assistant chief and then chief, nursing service.

At this point I realized I couldn't talk to patients, particularly if I knew they might die and this feeling went on for years compounding the guilt. How could I be a good nurse and dread patient contact? Each morning at 0630 I made rounds in the ICUs. The staff thought I was great, but I knew the truth. If I didn't force myself to visit patients, I wouldn't do it at all. I could not share with or console families at the stateside hospital

any more than I could have on the ship.

A *Repose* patient's father was a colonel stationed in Saigon. He had come aboard to be with his dying son. The son had multiple trips to the operating room. I would see the father in the wardroom looking for some kind of hope, consolation, and support, but I was unable to help him. I avoided him because I feared I would cry and, if the floodgates opened, I wasn't certain I could close them. I still feel remorse over that.

Specific stress hinted at, but not discussed openly, is the stress of being a woman in the combat arena in a primarily male environment. The woman becomes a substitute mother, a wife, a lover, a sister—the shoulder to cry on. You listened to the corpsmen, physician, ship's company officers, and enlisted—anyone who needs to ventilate and to talk about the sick father, the unfaithful wife, or the child on “pot” flunking school. You “ooh and aah” over the new baby pictures. Even the chaplain seeks out the nurse with his problems. It was okay to discuss problems with the nurse—the woman. The men seemed to be able to share some aspects of their lives with women that they could not, or would not, share with men. But, the nurse—the woman—would not share with anyone, not with other nurses, staff, or line personnel. We might have seen ourselves as judged weak, not being able to take it, and decided not to share our own problems with others—to tough it out.

The nurse accepted this role and responsibility. With all her concerns for patients, she worried about the amount of sleep the surgeon and anesthetist had and wondered whether or not there was a way she could keep from calling them for 1 more hour. She tried to keep the corpsmen, who were so tired and stressed, from getting into

difficulty. That sometimes meant having to take on the ship's commanding officer. The nurse had to console the chaplain who had experienced his first massive casualties. She had to tell him that no matter how hard we tried and prayed, we couldn't save the 18-year-old Marine with a gunshot wound to the head and who was already decerebrate. I have no problem with the nurse—the woman—being a consoler, comforter, and sympathetic listener. However, I feel that this role heightens the stress she has already been experiencing.

Although most were able to cope during the periods of heavy casualties, I think that many, including myself, felt the stress once the pressures were off and we were home. For me, understanding and admitting I had been through a stressful period was therapeutic. I have no difficulty visiting patients now. I can talk openly about experiences that were painful. That does not mean to say that I won't get teary-eyed. I think it is a phase of caring for casualties that we need to recognize that we are affected and are going to react to stress sometime or another.

For me, the stress of caring for casualties is like going to a supermarket where you are loading groceries into a paper bag. You only have the one bag and you keep piling those groceries in. If it doesn't overflow from the top, the seams are going to burst. It is my feeling that the personal stress experienced in caring for casualties will take its toll emotionally somewhere along the line. □

When the article was first written RADM Shea Buckley was the 9th Director of the Navy Nurse corps, Deputy Commander for Personnel Management, Naval Medical Command, Washington, DC, and Commanding Officer of the Health Sciences Education and Training Command, Bethesda, MD. RADM Buckley is now retired and lives in San Diego, CA.

Building a Mentoring Program

One Protégé at a Time

LCDR Frank H. Stubbs III, MSC, USN
LT Sarah B. Goldman, MSC, USNR

On 2 September 2003, amid much fanfare and excitement, Naval Hospital Jacksonville launched its new “Under My Wing” Mentoring and Sailor SMARTS (Sailors Motivated About Responsibility Toward Self-Development) Life-Long Learning programs. Approximately 100 hospital staffers attended the late morning Quarterdeck ceremony. Commanding officer CAPT John W. Sentell served as keynote speaker for the event.

Today, the programs are the product of 10 months of extensive work performed by the leadership group, a dedicated group of staff members who have been charged with managing Jacksonville’s innovative, two-pronged program.

The programs “Under My Wing” and Sailor SMARTS were designed to change the way mentoring and learning takes place within naval hospitals, in general, and Naval Hospital

Jacksonville, in particular. These programs were created as part of the commanding officer’s vision to provide service to the hospital staff. Quality care at Jacksonville essentially involves service to the fleet and their families, readiness, and service to the staff. The “Under My Wing” and Sailor SMARTS programs fulfill the third component of the hospital’s service-oriented tenet. “It’s our way of taking care of our Sailors and civilian staff members,” commented Sentell.

Navy-wide, the mentoring concept was one of Chief of Naval Operations ADM Vern Clark’s leadership goals for 2003. Under the CNO’s vision, every service member should be assigned a mentor. Jacksonville is leading the way with the successful launch of its complementary programs.

Sailor SMARTS is the life-long learning curriculum of the initiative. Five primary learning components or “pillars” serve as the foundation of this

program: career development, community and cultural enrichment, spiritual growth, financial security and planning, and education and life-long learning. Personal development in each one of the five pillars is important and will increase the chances of being successful both in the Navy and in life. The SMARTS program provides its participants with the knowledge and skills needed to be successful in life while the “Under My Wing” mentoring program allows for practical application of knowledge conveyed in various SMARTS curricula.

Sustaining a True Mentoring Program

Developed for implementation at Jacksonville by LCDR Frank Stubbs, a healthcare administrator, and LT Sarah Goldman, an occupational therapist, the “Under My Wing” Mentoring and Sailor SMARTS programs concepts were originally devel-

oped in 2001 onboard USS *Essex* (LHD-2), while forward-deployed in Sasebo, Japan. Stubbs served onboard *Essex* prior to his arrival at Jacksonville and created the “Under My Wing” mentoring program while assigned to that platform.

Goldman helped champion a new mentoring program similar to “Under My Wing” during her previous tour at U.S. Naval Hospital, Yokosuka, Japan.

The Sailor SMARTS Lifelong Learning concept is the brainchild of retired Navy chaplain LCDR David Mitchell, active duty Navy chaplain LT Alan Travers, and Stubbs. All three officers developed SMARTS while serving aboard *Essex*. “Under My Wing and Sailor SMARTS worked so well onboard *Essex*, I thought we could match and eventually exceed its success here at Jacksonville,” stated LCDR Ethan Josiah, head of Command Education and Training and a founding member of the leadership group

Unlike informal mentoring programs which exist at several naval commands, this “Under My Wing” mentoring program offers its participants several innovative features which will enable the program to sustain itself long after the members of the present leadership group have left the command.

To begin with, the mentoring program is formalized by way of an official Naval Hospital Jacksonville instruction. Participation is required for all first-term Sailors and first assignment junior officers and highly encouraged for all others.

Secondly, both mentor and protégé enter into a mentoring contract at the

beginning of the mentoring relationship. With help from a member of the leadership group, the protégé outlines goals and objectives within the contract that he/she hopes to achieve over the next 6 to 12 months. The mentor, in turn, indicates the courses of action he/she will take in enabling the protégé to reach his/her goals and objectives. The mentoring contract has been tailored to provide both participants with a win-win strategy. Either the mentor or the protégé has the option to “opt out” of a mentoring contract if there is not a “good fit” between the two. The leadership group will work to find both parties a new partner.

“There are no negative consequences for opting out of a mentoring contract,” said Josiah. “At first indication that a mentoring relationship is in trouble, we will try to identify the cause of the problem and solve it, if it is practicable. Otherwise, we will notify both parties that the relationship is being terminated, we’ll provide constructive feedback and we’ll work to find both parties a new partner,” he explained. A third feature of the program is the Mentor-Protégé Survey, which is provided to both parties periodically during the relationship.

When the program was launched a total of 140 persons comprised the total number of mentors and protégés. Today, the program boasts more than 450 mentors and protégés and that number is growing every day. In order to keep the program current and to provide members with the tools they need to be successful, the command needs to know how the leadership group is managing the program and how they can make it better.

Creating a Mentoring Culture

Sentell, a firm proponent and beneficiary of mentoring explains, “Mentoring is not new to the Navy or to the Medical Department. Most of us who have been in the Navy for more than 5 to 10 years have had someone who has provided us with career guidance or help in making an important assignment decision. That person was a mentor. The “Under My Wing” mentoring and Sailor SMARTS programs have enabled us to create a mentoring culture within the hospital. It is our opportunity to develop our staff members, especially our first-term enlisted Sailors and first assignment junior officers, into mature, accomplished, goal-oriented, and focused professionals. I’d like for each one of these individuals to have the opportunity to be a protégé and benefit from the experience and knowledge of a mentor.”

By participating in one or more of the programs, Sailors and civil service employees have been provided opportunities to acquire knowledge and information in areas vital to their success in the Navy and essential to their success and enjoyment as human beings. Several speakers have been invited to the campus to teach staff members how to live more fulfilling and satisfying lives. “We may not be able to get Dr. Phil to speak with us, but we’ll continue to bring in experts who are equally talented and articulate to share with us their knowledge,” Sentell said.

As a result of bringing speakers and thinkers directly to the hospital campus, Sentell and his leadership group have created a true learning environment at the hospital. “Every-

thing we do here revolves around increasing the level of care we provide our patients. If our Sailors and civil service staff members achieve a greater level of personal satisfaction in their lives, this will necessarily translate into a higher level of care and service being provided to our patients and beneficiaries. We also expect retention among our hospital corpsmen to increase because we are providing our Sailors with an environment that is conducive to learning and individual growth,” Sentell explained.

Measuring Success

Defining and measuring success for a mentoring program can be challenging. Outcome data is often overwhelming, partly due to the individualized nature of mentoring relationships. The Search Institute has published guidelines for evaluating a mentoring program, which include surveys, focus groups, and interviews. Following their lead, the leadership group conducted an anonymous survey directed to both mentors and protégés 7 months into the program. The 20-question web-based surveys assessed factors such as the mentoring relationship’s effect on advancement, adequate time for mentoring, the rewards of mentoring, leadership support, and effects on job satisfaction. Opportunities were also provided for the respondents to offer suggestions for the program and to identify specific accomplishments as a result of mentoring.

The results of the survey were overwhelmingly positive. Mentors and protégés answered survey questions separately. Eighty percent of the protégés agreed that having a mentor has been a rewarding experience, while 87 percent of all protégé respondents believed that their chain of command supported their participation in the program. This same 87 percent stated that they would recommend the mentoring program to other Sailors. More than half the protégés surveyed experienced greater job satisfaction as a result of mentoring.

Survey results from mentor respondents were equally positive. Eighty-seven percent of the mentor respondents agreed that mentoring has been a rewarding experience. Thirty-three percent of the mentor respondents stated that others noticed a positive change in their protégé as a result of mentoring.

There were numerous examples of individual achievement provided in the survey results. The Sailor SMARTS program was also recognized in the survey as having a positive effect on Sailors at the hospital.

Sharing “Under My Wing” and Sailor SMARTS

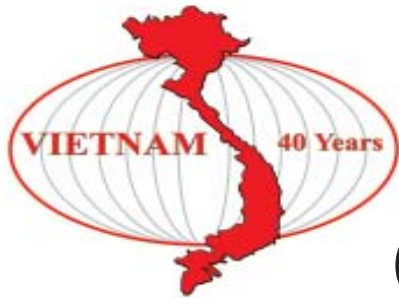
The leadership group believes it has developed a winning formula for mentoring success. Through the combined strengths of the “Under My Wing” Mentoring and Sailor SMARTS Lifelong Learning programs, Naval Hospital Jacksonville has created a

successful strategy for taking care of Sailors and civil service staff members while simultaneously improving the quality of service provided to all its beneficiaries. Jacksonville has expanded the reach and breadth of its programs. All six of its branch medical clinics (Athens, Albany, Atlanta, and Kings Bay, GA.; Mayport and Jacksonville, FL.) will soon have identical programs. “This is an institutional effort,” said Sentell. “We will indeed establish a true mentoring and learning culture here at Naval Hospital Jacksonville.”

Naval Hospital Jacksonville is willing to share its programs with any command within the Navy and the Department of Defense. Programs starter kits, in the form of a CD-ROM and instructional binder, have been exported to NAS Jacksonville, Naval Hospital Camp Lejeune, USS *Tarawa* (LHA-1) in San Diego, and Naval Reserve centers. For more information on how “Under My Wing” and Sailor SMARTS can benefit your organization, please contact LCDR Stubbs at (904) 542-9444, LT Goldman at (904) 542-7503, or LCDR Ethan Josiah, at (904) 542-7464. □

LCDR Stubbs is Head of the Patient Administration Department at Naval Hospital Jacksonville, FL. He is currently deployed with Expeditionary Medical Unit-10, Marine Corps Forces Central Command at Camp LeMonier, Djibouti, Africa.

LT Goldman is the Assistant Department Head of Physical and Occupational Therapy, Naval Hospital Jacksonville, FL.



Charlie Med A Physician's Vietnam Journal

CAPT William B. Mahaffey, MC, USN (Ret.)

Part II

Soon I felt very much a part of the Charlie Med team. That team was much more than just a few surgeons, anesthesiologists, and OR techs. By the end of my tour in Vietnam, about 150 Navy and Marine Corps officers and enlisted men made Charlie Med the noble outfit that it was.

The only other anesthesiologist in December 1965 was LCDR Dave Torpey, a superb scholarly Navy-trained anesthesiologist whose arrival in Vietnam preceded mine by 6 or so months. Among his countless attributes, Dave was a real neatnik! And Dave also had this blasted electric iron! While most of us were necessarily content to wear never-quite-dry wrinkled utilities, Dave, with his precisely-trimmed moustache and neatly-coifed hair, wore utilities that were smartly pressed with a crease.

In December 1965, there simply were no surgical caps or scrub suits available in the strained supply channels to be worn in Charlie Med's ORs but Dave had one or two of each, most likely mailed to him by his wife or

former co-workers. Not only did Dave wear a scrub shirt and surgical cap while the rest of us sported T-shirts and went bareheaded in the OR, his cap and scrub shirt were always neatly pressed with creases. However, he was equally fastidious about providing every mangled Marine with the very finest anesthetic and pre- and post-operative care under unbelievably demanding conditions. As a 6-month veteran in Vietnam, Dave taught me an immense amount about blood volume restoration and the consequences of massive blood transfusions while I, a neophyte, was rapidly getting my feet on the ground at Charlie Med. No stateside training could have provided me with the expertise that he shared with me.

The majority of our specialized physicians were necessarily general surgeons and orthopedic surgeons. There were Dick Escajeda, Ray Ellingson, Greg Cross, Steve James, Jim Chandler, Bob Knapp, Guy Townsend, and Roger Houser, just to name a few. There was, however, always the need for the services of an internist or two,

though we sometimes had no fully-trained internists on board. Our sizable malaria ward was often overflowing with trembling fever-ridden Marines. Other than the recovery room/ICU, the malaria ward was the only air-conditioned ward at Charlie Med. All other wards were screened and open to natural ventilation. Supposedly, all of us deployed to Vietnam were required to swallow a chloroquin-primaquin tablet once a week to prevent malaria. For those of us living and working in the relative luxury of a medical battalion, taking that required weekly malaria prophylaxis was no problem. One day each week, a bowl full of the tablets showed up in the mess hall. But for a Marine desperately hoping only to survive each day and night on the run or in his muddy foxhole, remembering to take a weekly tablet to prevent malaria was just asking too much. Chloroquin-primaquin was also rumored to cause diarrhea, and that also discouraged its use.

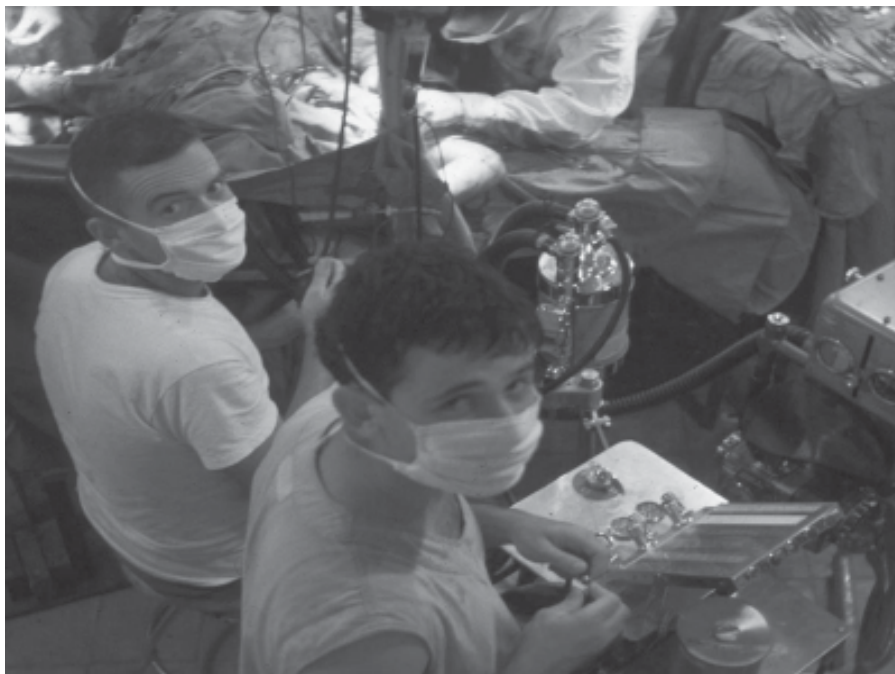
Penicillin-resistant gonorrhea was rearing its ugly head in Southeast Asia.

And a form of very severe diarrhea was capable of disabling an entire company of Marines almost as effectively as a land mine might. Pneumonia was not uncommon among Marines on the front lines in the wet winter months. When an internist was not available to oversee the care of these non-surgical patients, our numerous general medical officers did an outstanding job of getting them back on their feet.

Combat fatigue and other psychiatric/psychological disorders kept our extraordinarily sane psychiatrist quite busy. He was an exemplary physician but he never offered to help out as a physician in the triage tent when we were swamped with casualties. He preferred to remain in his hooch.

Other surgical specialists included an oral surgeon to care for facial injuries and, for a brief period, a neurosurgeon. Later a civilian-trained vascular surgeon joined our staff. The commanding officer soon realized that the two very busy operating rooms in a medical battalion were just too primitive to support a neurosurgeon's specialized work properly. Even more significantly, the number of neurosurgical cases was not that large. Marines wore helmets in combat. Head injuries were usually either fairly minor in nature or instantly fatal. Therefore Paul Pitlik, our neurosurgeon, was transferred to the new Naval Support Activity (NSA) Hospital—a true hospital with nurses and chilled drinking water—being constructed by Marble Mountain near Danang. There he would have better facilities to handle the head injuries that could be helicoptered in to NSA from more primitive units such as Charlie Med after being stabilized.

While some might assume that we merely stabilized combat casualties



Author and HM3 Jay Rodney at work in the new OR. Photo taken by Dave Torpey.

Photos courtesy of author

for further transfer, in a Medical Battalion that practice applied only to neurosurgery patients, and rare casualties medevaced directly to Clark AFB Hospital in the Philippines. The overwhelming percentage of our patients received definitive care before being medevaced out.

We had a number of dental officers on the staff. The dentists and their dental technicians ran quite an active dental clinic. Some of the dentists and dental techs were willing to be occasional blood donors when we needed ultra-fresh blood for transfusion. Several of the more highly motivated dentists also became quite proficient in assisting with the care of incoming Marines with relatively minor wounds requiring only debridement. Other dentists remained very much uninvolved. Of my two dentist hoochmates, one was a rather good artist who completed a number of oil paintings of our surroundings, one of which

he gave to me. The other dentist was a great fan of classical music. He introduced me to Beethoven's "Pastoral Symphony," which I will forever associate vividly with Vietnam when I hear it.

A number of Medical Service Corps officers, most of whom had been hospital corpsmen at one time, were essential to the efficient operation of Charlie Med. Their duties were to ensure that medical records, the medevac system, mail delivery, medical supply, graves registration, and all the inevitable administrative paper work—orders and fitness reports included—were handled efficiently, even in a combat zone.

We had no nurses at Charlie Med, in accordance with Marine Corps policy, although late in 1966, a male nurse anesthetist was ordered in. All nursing functions in the ORs and all patient care on the wards were expertly provided by Navy hospital

corpsmen. These enlisted men, many of whom were young with minimal experience, performed exceptionally well. My immense respect for them will never falter.

Two chaplains were attached to Charlie Med, one Protestant and one Roman Catholic. The latter was Father John Glynn, a Bostonian, who had been recognized by the Marine Corps for his valiant sense of duty in ministering to Marines in a combat zone. As an anesthesiologist, I would normally be at the head of one of the more seriously injured incoming casualties as they were receiving initial care. I can only wonder how many such casualties I backed away from slightly so that Father Glynn could administer Last Rites, as the sacrament was called then. It was a privilege to maintain contact with Father Glynn through his military career. Following his retirement from the Navy, he continued his ministry to military personnel as an Auxiliary Bishop in the U.S. Military Archdiocese.

The H&S Company of our medical battalion also included a sizable Marine detachment. Some of those Marines were grateful for the relative safety of duty in an outfit like ours while others found it somewhat humiliating to be stationed in Vietnam with the likes of "Pecker Checkers" (hospital corpsmen), "Fang Fairies" (dental technicians), and doctors who couldn't climb a rope. Nevertheless, the Marines' services were invaluable in running the mess hall, manning the communications shack, maintaining motor transport, guaranteeing our water supply, burning out the shitters several times a week, running the temperamental generators, etc. They were also immediately there on the spot with their expertise when casu-

alties arrived carrying—internally or externally—live ammunition, unexploded grenades or "Willy Peter" (spontaneously combustible white phosphorus from illuminating flares).

The Geneva Convention allows hospital corpsmen to be armed while guarding the perimeter of a medical unit in a combat zone, so Marines were spared the sentry duties at our perimeter. Like many hospital corpsmen, Marines attached to a medical battalion were eventually rotated out to line outfits. I recall the day that the Marine Corps captain who headed our Marine detachment came to his final officers' call with us before departing for a front lines outfit. He and the rest of his Marines were quite often present in the triage tents and even in the ORs helping out where they could or just showing a genuine concern for their own. Showing emotions is not part of a Marine's composition, but this Marine Corps captain had a few tears in his eyes when he said, "If I get shot up bad out there, I hope that I come back here. You guys are 'Numba One.'"

If a corpsman was fortunate enough to have received specialty training, perhaps as an OR tech, X-ray tech, morgue technician or lab tech, he would most likely remain at Charlie Med in relative safety during his entire 13-month tour. But those younger corpsmen having received no specialty training other than the 8404 NEC (Field Medical Technician) would often spend only a part of their 13-month Vietnam tour with us at Charlie Med as valuable general duty corpsmen. Unfortunately, they would then, almost without fail, rotate to infinitely more hazardous duty with Battalion Aid Stations (BASs) and with combat Marines, where surviving each day and night was a gift from

God. One such unspecialized corpsman was young Hospitalman Aldon Asherman. While he was with us at Charlie Med, he had an amiable personality and a remarkably wholesome attitude about work. Regardless of the time of day or night, when casualties came in and work was to be done, he was there doing whatever he could, and always with a smile. Eventually it was his time to be rotated to a front-line outfit. We hated to see him leave but no more than we hated to see any of our young corpsmen go out to face the hazards of battle. One summer day, as a helicopter was unloading its casualties at Charlie Med, we recognized Doc Asherman among them. His battle injuries would prove to be incompatible with life. Upon arrival in the triage tent, he seemed to be holding on to life but probably was unaware of his surroundings. Yet something made us believe (or hope) that he realized briefly that he was back with his beloved team at Charlie Med.

Thanks to daring and unselfish helicopter crews and to courageous hospital corpsmen in the field, very, very few casualties died after they arrived at Charlie Med. HN Aldon Asherman was an exception. I still remember hearing one of the surgeons just begging this young man to hang on while we cared for him, but to no avail. His untimely death in our hands while we were attempting in vain to save his life brought toughened grown men to tears. In the 1980s, when I was stationed in Washington, DC, only several blocks from the Vietnam Wall, I regularly found Aldon Asherman's name on the Wall and paid grateful homage to one very fine Navy hospital corpsman.

The chances that a wounded Marine would survive his injuries in Vietnam were markedly better than the

statistics for the Korean Conflict had reflected. Much of this improvement, was, of course, due to significant advances in medicine, especially in the areas of blood and fluid replacement, antibiotics, and anesthesia techniques. I would be foolish not to brag about that. But I also must brag about those marvelous machines called helicopters and the gutsy, courageous crews that flew them in Vietnam. Even in the worst weather, casualties arrived at Charlie Med amazingly swiftly after they were injured thanks to helicopter evacuation. Without that opportunity to stop blood loss, start resuscitation, and restore blood volume very soon after a Marine was injured, many more casualties would have died prior to their arrival at Charlie Med. Even if the casualties arrived alive, our chances of saving them would have been greatly reduced if more time had elapsed between injury and resuscitation. If a Marine arrived alive at Charlie Med and we had a reasonable opportunity to start treatment, his chances of leaving the country alive were very good indeed.

The valiant Marine Corps pilots and crews who flew medevac missions in Hueys and 46s were courageous and unselfish beyond description. They responded over and over and over to calls to evacuate severely injured Marines from an ongoing firefight or following a land mine explosion, with no avoidable delay, even in the very worst weather. Marine Corps intelligence kept the medical battalion informed of battles in progress, but only rarely did we receive formal warning that casualties were on their way in to us. They simply arrived when we heard the helicopters, all too often in overwhelming numbers.

Each type of helicopter has its own identifying sound, and even at night

when we were unexpectedly awakened by helicopters approaching Charlie Med from over the rice paddies, those identifying sounds gave us some warning as to the nature of what the helicopters were carrying. We had some hint as to how many of us should respond without waiting to be called by the first surgical team on call that night. The unmistakable rapid thwop-thwop-thwop of a small Huey (UH-1), especially at night, let us know that the crew of this agile helicopter had most likely just snatched several severely injured Marines from a firefight or a land mine explosion. The Hueys could carry only several wounded Marines under normal circumstances, but more often than not, those they carried were severely injured. The grinding whine of the much larger twin-rotored '46 helicopters (CH-46) warned us that we could probably expect a much greater number—perhaps 50-60 in each helicopter! And unlike those the Hueys might bring in, these casualties were most likely less severely injured. But there were absolutely no hard and fast rules as to what they carried. Unfortunately, CH-46s also frequently ferried dead Marines—sometimes large numbers of dead Marines—into us following a battle. A third type of helicopter with a unique sound was a small twin-rotored Air Force helicopter from the Danang Air Base. They arrived only infrequently but usually carried a burn victim or single injury of some sort from the airfield.

Helicopters normally followed vectors which allowed them to make their approach to Charlie Med from over the rice paddies to the east toward the far side of our helicopter pad. One day, a helicopter approached atypically from directly over our compound, almost brushing the top of the mango

tree as he landed. His landing on the pad was surprisingly forceful. As was their routine, our corpsmen ran out to begin unloading the casualties the helicopter carried. Only moments later did we discover that one pilot had died from a gunshot wound and the other pilot had landed the helicopter safely with a gunshot wound to his shoulder from the same sniper's fire.

The overwhelming majority of casualties arrived at Charlie Med by helicopter. Only rarely did a jeep or truck bring in an injured Marine.

In medicine, triage is the art of rapidly assessing and instantly assigning a priority to each of many casualties as they arrive at a treatment facility. This is so that those casualties who need the most urgent care and can be salvaged are shunted directly to the location where resuscitation and intensive care is immediately available. The dead and those few who cannot be salvaged are shunted to another area. The remaining casualties are sorted into categories depending on how urgent their needs are considering the resources available, and shunted elsewhere as appropriate.

The art of triage is learned on the job and cannot be learned from a book. Triage cannot be delegated to an indecisive inexperienced person. At Charlie Med, the day's designated triage officer was always a surgeon who was positioned at the entrance to the triage tent where he instantaneously evaluated each casualty being off-loaded from helicopters. Those needing immediate intensive care were taken directly into the triage tent. The dead were moved to a designated area outside the triage tent. Those with significant non-life-threatening injuries were sent to a nearby tent where IVs were started and injuries were evaluated and treated under lo-

cal anesthetic when possible. Casualties with relatively minor injuries were carried to a large holding area under a huge mango tree for evaluation. They would be moved back into the treatment area for definitive care just as soon as resources permitted and the backlog diminished.

While the triage officer's skills were crucial to our operation, the experienced hospital corpsmen who were rapidly off loading casualties from the helicopters could, more often than not, I'm sure, predict which direction the triage officer would point.

The purpose of triage is to make the very best use of existing finite resources so that the greatest number of injured personnel can be treated commencing with salvageable casualties with the most critical needs. On

rare occasion, a moribund casualty would arrive who was technically alive but whose injuries were so extensive and brutal that they were deemed to be incompatible with survival. The decision to allow death to come peacefully was usually made by two or more physicians who consented silently with a nod of the head. The rationale was that by not tying up scarce resources—an operating room, an entire surgical team, and perhaps transfusing dozens of units of blood—in vain, the life of another gravely injured but salvageable Marine could be saved using those same resources without delay. We were not playing the role of God, but were practicing the ultimate form of compassion.

In the triage tent, when casualties were heavy, the most seriously injured were met with no delay by spontane-

ously-formed surgical teams, typically including general and orthopedic surgeons, and anesthesiologists to start large-bore IVs for restoring blood volume, and often to maintain compromised airways. Also there on the spot without delay were lab techs who drew blood specimens to start cross-matching appropriately large amounts of blood. No one told them how much blood to set up. From experience, they knew how much to set up. And without fail, they stayed ahead as the blood was transfused during resuscitation and surgery. A patient affairs corpsman silently examined dog tags and recorded the names and outfits of each casualty, except when dog tags were missing. Almost all casualties required X-rays, and the casualties that the triage officer decided needed attention in the ORs with the greatest urgency were the first to be X-rayed. The X-ray techs did not have to be told what part of the body to X-ray. They knew. Almost all casualties were muddy and dehydrated when they arrived. Their clothes were cut away and, when possible, their flak jackets, boots, and helmets were recycled. On their way to be X-rayed, they were thoroughly drenched with water to wash away some of the mud and grime.

My medical training had long ago toughened me to the sight of death, but none of us at Charlie Med was accustomed to seeing the large numbers of dead Marines and hospital corpsmen we often processed. When dead Marines arrived in large numbers, they were promptly, but with simple respect, moved to a designated area just outside the triage tent. Sometimes, I felt like they were piled like so many logs. Our Catholic chaplain tended to these dead Marines' spiritual needs just as he tended to the



Non-surgical patient (diarrhea or malaria) carrying IV from six-holer.

needs of living Marines. Each dead Marine's status had to be formally documented by a physician after the paperwork was completed. I signed my share of those "pink sheets." I was especially bothered when a deceased Marine's protruding left hand revealed a wedding band. I knew that he was dead, yet his wife and family at home were still hoping against hope that he was safe. Once processing was complete, the bodies were removed to graves registration where they were placed in body bags in our refrigerated field morgue until they could be flown out of the country.

My cousin is a funeral director and a veteran of World War II. He told me how impressed he was by how professionally embalmed and how well-dressed in "dress" military uniforms these Vietnam casualties invariably were when their remains were returned to their hometowns for funeral services.

Relatively few injured Marines remained in-country more than 48 hours following surgery. Exceptions were some minor injuries which would not require lengthy hospitalization and/or rehabilitation. One Marine who remained in country after treatment had received a chest injury which resulted in a collapsed lung. He required little more than a chest tube for a few days. When he was carried to the recovery room, he proved to be the brother of the senior recovery room corpsman.

Except in the most inclement weather, we arranged outgoing medevacs every other day and sometimes more frequently when casualties had been heavy. Some of the most critically wounded, especially in weather which made roads impassable, were ferried by helicopter to waiting medevac airplanes at the Danang Air Base. Later in the year,

some of these critically injured post-operative patients would be ferried by helicopter out to USS *Repose* (AH-16), a vintage Navy hospital ship that arrived in Danang Harbor in 1966. When *Repose* arrived, she also began receiving casualties directly from the field, but initially helicopter pilots claimed that they were reluctant to land on *Repose's* small helicopter pad at night, especially in bad weather.

When weather permitted, most post-operative patients were transferred from Charlie Med to the Danang Air Base by Air Force buses rigged to carry litter patients. From there they were flown to U.S. naval hospitals in Japan and Guam, and to Clark Air Force Base Hospital north of Manila in the Philippines. In time, those who could not return to combat—or if they had received their second Purple Heart in Vietnam—were flown to stateside military hospitals as close to their homes as possible. The naval hospitals at Oakland and Philadelphia were tasked with becoming the Navy's primary orthopedic rehabilitation hospitals for casualties from Vietnam. Their workload was indeed great!

Occasionally, if resources permitted, one of the physicians from Charlie Med would accompany a Marine who was unstable or who had received a particularly precarious injury, on the medevac flight. A secondary benefit of that practice was that it gave one of us the chance to spend a day or two in "civilization" while awaiting a return flight. I had my sole chance to accompany such a casualty, a Marine with a sizable round of ammunition which had penetrated his chest wall and stopped only millimeters from the great vessels arising from his heart. I still have photographs of his X-rays. Our surgeons were reluctant to ex-

tract that precariously positioned round and elected to send me along when he was medevaced to Clark AFB Hospital. The flight was uneventful. I followed the patient to the OR where the round was removed without incident. In retrospect, I wonder what I possibly could have done for that Marine if the round had suddenly eroded into his aorta during the flight. While in the Philippines, I was invited to a poolside barbeque put on by the Clark AFB Hospital anesthesia department. What a treat.

One small group of "casualties" which were usually retained in-country for recuperation were those Marines who had self-inflicted foot wounds, often incurred "accidentally while cleaning their personal weapons" possibly in a desperate attempt to be shipped out of Vietnam and even home.

We were a medical battalion and not a hospital. Yet the care we provided was unquestionably definitive and far more than mere "stabilization for further transfer." But we had neither the space nor the resources to provide long-term post-op care and rehabilitation. The medevac system was essential and very well organized. (To be continued) □

Dr. Mahaffey is retired and resides in Upper Sandusky, OH.

Education Returns to BUMED Through Webster University

HM1 Lori Amodeo, USNR
LCDR Eddie Oestreicher, MSC, USN

From its establishment as the original U.S. Naval Observatory in 1844, through its evolution to the Naval Museum of Hygiene in 1894, and the U.S. Naval Medical School in 1902, to the Bureau of Medicine and Surgery (BUMED) in 1942, the hilltop in Washington, DC's Foggy Bottom neighborhood has a history of teaching.

This year marks another milestone. BUMED, through the Naval College Campus, will enter into a collaborative agreement with another historical institution. Webster University has been chosen as the educational provider for civilians, government employees, military members, and their family members. Initially, Webster will offer graduate programs focused in business with various healthcare, marketing, and information technology specializations. In the very near future, the campus will have programs in leadership and, potentially, homeland security. Beginning on 14 April 2004, Webster University was located on the Bureau of Medicine and Surgery compound.

Webster was founded in the early years of the 20th century by pioneering religious women, the Sisters of Loretto, one of the first religious communities of women in the United States. The university during this time was known as Webster College and was limited to women at a time when secondary education was rare for the female portion of the populace. In 1962, these innovative Sisters decided to open the college to male students. By 1968, Webster College was completely coeducational, offering graduate degrees in teaching.

Webster began its expansion efforts with a campus in Kansas City, MO. Over the next 4 years the uni-

versity continued to expand to include masters degrees in arts and business administration. Webster campuses now stretch around the world from Kansas City, MO, to Geneva Switzerland, to Shanghai China.

As one may see, a college campus located at BUMED is a wonderful match for Webster University. Both organizations have a rich history of growth, development, and innovation. □

HM1 Amodeo drills with Reserve Unit 106, Bureau of Medicine and Surgery, Washington, DC.

LCDR Oestreicher is the former Director, Personnel and Manpower Management (M10-1), Bureau of Medicine and Surgery, Washington, DC.



Photo courtesy of authors

RDML Dennis Woofert, DC, Chief of Staff and Program Executive Officer, BUMED, opens the ceremonies welcoming Webster University.

Get Moving, Navy

CDR Lee Bridgewater, NC, USNR
CAPT Bruce K. Bohnker, MC, USN
CAPT Lynn Klanchar, NC, USNR (Ret.)

“Our goal is to create and maintain a fit and healthy force. That goal extends beyond the battlefield, to the home front. Encouraging healthy lifestyle choices and avoiding obesity, in particular, are among the most important factors in achieving this goal.” VADM M.L. Cowan, Surgeon General of the Navy.

Obesity has now become the second leading cause of preventable death **after** smoking (1) and will surpass smoking if allowed to continue. Since 1980 obesity rates have doubled among children and tripled among adolescents. Sixty-four percent of Americans are overweight and more than 30 percent are obese. Fifteen percent of American children between 6 and 19 are overweight.(2) Our Navy personnel are not immune from this spreading public health hazard. Information from the Bureau of Naval Personnel (BUPERS) Physical Readiness Information Management System (PRIMS) database demonstrates that the mean body mass index (BMI) increases with age for Navy personnel.(2,3) Children and spouses within the Navy family are not exempt, and our retirees continue to be at risk. This problem has large implications for Navy medicine since increasing weight is a risk factor for multiple medical conditions including diabetes, heart disease, and stroke. Reducing those risk factors will reduce the long-term healthcare costs of our beneficiaries and is an important strategy for Navy medicine.(4)

Responding to this public health threat, the Assistant Secretary of the

Navy for Manpower and Reserve Affairs and the Navy Surgeon General established an integrated product team to promote optimal fitness and nutrition. The group included representatives from Navy and Marine Corps, civilian personnel, Defense Commissary Agency (DeCA), Navy Exchange Command (NEXCOM), BUPERS, and Center for Personal Development (CPD) under the leadership of the Navy Environmental Health Center (NEHC), Portsmouth VA. NEHC functions as Navy medicine’s public health and preventive medicine agency, with expertise in both health promotion and population health. The group reviewed current best practices including the Community Preventive Services Task Force and Centers for Disease Control and Prevention (CDC) recommendations from the Healthy People 2010.(5) After reporting these to the Navy Surgeon General, the group was tasked to initiate a pilot for implementing these best practices and recommendations across the Navy as part of “Get Moving Navy.”

After some initial liaison, the leadership of Naval Air Station (NAS) Oceana stepped forward to be the pilot site for the campaign in January 2004. The base commander, officer

in charge of the Branch Medical Clinic, and Morale, Welfare, and Recreation (MWR) directors were briefed on the proposal. A key component of the campaign was establishing the base Fitness and Nutrition Council under the direction of the base executive officer. The council included leaders from across the base who had a strong interest in fitness and nutrition, including members from the Branch Medical Clinic, NEX/DeCA, MWR, Fleet Family Support Services, Civilian Personnel (HRO), CPD as well as representatives from the tenant commands, with ongoing support from NEHC. The working group reviewed base statistics from PRIMs/PARFQ, Physical Fitness Assessment (PFA), Preventive Health Assessment (PHA), and high-medical risk beneficiaries such as those with history of diabetes, hypertension, obesity, etc.(6)

The council members completed a formal needs assessment for the base, which included an environmental survey of base facilities, and review of ongoing fitness and nutrition support. Focus groups were conducted on target populations for the campaign, which included active duty and reserve personnel; active duty personnel in the Fitness Enhancement Program (FEP); spouses, civilian employ-

Body Mass Index (BMI) = Weight (kg)/Height (m) ²	
CDC Criteria	
Normal	Less than 25
Overweight	25-30
Obese	Over 30

BMI of 25 (normal)	
Height	Weight
64 ins	150 lbs
68 ins	164 lbs
70 ins	174 lbs
74 ins	194 lbs
(2)	

ees, and retirees; and personnel with high-risk medical conditions.

Using criteria from the CDC Healthy People 2010 (objective 22-2), one goal of the campaign was to increase healthy lifestyle awareness and participation in physical activities. One metric became the number of people participating in 30 minutes or more of moderate physical activity 5 or more days per week. The use of pedometers as a tool was encouraged to motivate and more accurately track this activity. Interactive websites available at no cost were advertised for registering, monitoring, and providing feedback for tracking this goal. Two of the websites included are www.americaonthemove.org and www.presidentschallenge.org.

In March 2004 articles began appearing in the *Jet Observer*, the command newspaper, promoting the program through testimonial stories and encouraging registration. A local flavor for the campaign was maintained by including the base title into the logo as “**Oceana-Dam Neck IN MOTION.**” Their logo incorporated the

FA-18 aircraft that is assigned to the base. The logo also reflected the base leadership’s dual responsibility for Naval Air Station Oceana as well as the adjacent Naval Base Dam Neck.

The pilot site at NAS Oceana will continue through Spring and Fall 2004 PRT cycles, and monitor base fitness and nutrition issues. An important part of that assessment is review of available food choices all beneficiaries have at the various facilities. Personnel assessed vending machines for healthy snack choices, reviewed menus at the galley and officer/CPO clubs to look at caloric intake, assessed healthy choices available at the Food Court, and researched healthy food options available at the commissary.

The needs assessment and data gathering for this pilot program are ongoing processes. The base council will need to be an ongoing entity, continually looking at the progress at the base level as well as individual components, the menu/snack/food choices available on a regular basis, the FEP program’s success rate, and the subsequent PRT/PRIMS statistics in order to measure the program’s impact on beneficiaries and the program’s success/need for improvement. Ulti-

mately, the pilot program will serve as a template for campaigns on other Navy bases to improve the Navy’s overall health and wellness of all members. The campaign to increase physical activity and reduce obesity is everyone’s responsibility. And that means Navy medicine, line leadership, and the individual Sailor.

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Seven Secrets for Having Patient Patients

CDR James C. Horspool, MC, USN

Since graduating from medical school in 1987, I have had my share of experiences both rewarding and frustrating, as have most people in healthcare professions. I have also spent considerable time discussing concerns over current trends in healthcare. Healthcare providers frequently tend to feel frustrated that healthcare has been largely institutionalized, and that their patient care is largely dictated by institutional managers. Other frustrations tend to center on patient attitudes: inappropriately demanding, non-compliant with treatments or follow-up, overly emotional or otherwise irrational, etc.

Healthcare consumers complain of impersonal and, hence, personally inadequate care that they receive. They frequently seem to feel that doctors do not listen or do not care. Common complaints include: visits are too short; doctor hurries out too fast; doctor doesn't hear my concerns, answer my questions, or explain my diagnoses or treatments; diagnoses are inaccurate or inconsistent; and even "how clueless they all are."

It is interesting that both providers and patients seem to have frustrations with the institutionalization and depersonalization of healthcare. My experience as both a provider and con-

sumer of healthcare indicates that most people deeply desire to be cared for by a person, not by an institution. They want to be cared for by well-trained and intelligent professionals. They also want those professionals to recognize that they are human beings—people with concerns, anxieties, hopes, dreams, and *lives to live*, not just body parts with maladies that fit into those little DRG boxes with the right ICD-9 codes beside them. In the varied venues in which I have practiced medicine (tertiary medical centers, rural office-based practices, and walk-in outpatient clinics), I have found the patient needs and desires described above to be uniformly consistent regardless of the setting.

My experience in healthcare has reinforced to me the validity of a principle expounded by Stephen Covey many years ago—focusing my efforts in my sphere of *influence* improves effectiveness and *expands* my influence. Simply complaining about frustrations which are outside my immediate influence accomplishes nothing. (1) If, as healthcare providers, we continue to simply complain about our frustrations as products of bad systems, unreasonable patients, or other uncontrollable vagueness, it is likely that we will continue to be frustrated.

If, on the other hand, we identify things already within our ability to influence and work to improve them, job satisfaction will almost immediately improve. In addition, we will find our influence to effect additional improvements in others expanding also.

I present here a few basic principles and practices which, if incorporated into our health care delivery, can produce tremendous benefits to both providers and patients. Readers will note that most of the "secrets" presented below are not very secret at all. The first four are routinely taught in clinical training programs but too easily fall into disuse or misuse if other pressures are allowed to predominate. The others are a natural outgrowth of the proper application of the first. When I apply these "secrets" consistently, it improves my effectiveness, my job satisfaction, and the satisfaction of my patients; thus everybody goes home *and* comes back happier and healthier.

The Secrets

1. Care about your patient

Make it your personal, internalized goal to *help* your patient, not to *finish* the patient encounter quickly. This must come from *within* you, and it may require some hard internal ad-

justments, particularly when patients are cranky, complicated, or puzzling diagnostic dilemmas (or all of the above) on a hectic day. Sometimes the urge to just do whatever gets them out the fastest is a huge temptation. Most of us, when interviewing for professional school, responded to questions about our motives for entering the healthcare field with an assertion of our desire to help people. Yet, in the heat and press of hectic schedules, our altruistic motives sometimes erode into, "What is the quickest way to *finish* with the patient?"

It should be remembered that *pre-tending* to care, will not work; your caring must be genuine and internal. Do this long enough, and you won't have to think about it. You will *be* it.

2. Listen to your patient

In clinical training programs, they called this "taking a medical history," and it is usually the best, most important source of diagnostic information available to clinicians. Yet, it is often the most neglected of all skills. In 1999, a study was published in the *Journal of the American Medical Association* in which 300 patient visits with primary care physicians were recorded and analyzed. Physicians solicited patient concerns in only 75 percent of those visits. Physicians "redirected" patients' opening statements (stopped listening) after an average of 23.1 seconds. Only 28 percent of patients were able to complete their initial statement of concern and did not return after "redirection."⁽²⁾ Twenty-three seconds!

Listen with the belief that the patient is right. He may have picked the wrong diagnostic words or gotten misleading information because he did not have the tools to sort out the significance of his signs and symptoms,

but patients are usually right about *something*! Listen empathically, and listen long enough to find out what it is your patient is right about!

Ask additional questions. If your patient begins a meandering monologue that is taking you down irrelevant paths, gently redirect him by asking questions that will clarify his concerns or complaints to you. Learn to ask the questions that will help you and your patient focus down on the relevant diagnostic details.

3. Touch your patient

In clinical training programs, they called this "doing a physical exam." It is usually the second most useful source of information and should be guided by your history. Too often, however, clinicians go through a series of quick, cursory motions as a sort of obligatory preface to the labs and/or x-rays that they have already decided to order, or to the prescriptions they have already decided to write.

Most of us were taught to have some sort of system to our physical exams, but don't let your system be a substitute for thinking. All physical exams are not alike, and each physical exam should be thoughtfully guided by the medical history already obtained. Remember that most of your patients did not have a "physical diagnosis" course in school, so inform your patient about each aspect of the exam before you do it. Ask permission before touching, and let your patient know how the exam is progressing. Your patient is going to be much more patient for a physical exam with no unpleasant surprises.

4. Order labs, x-rays, and other studies that will add to or clarify the existing picture

Before ordering studies, ask yourself three questions:

- What will this add to the diagnostic picture that is still unsure?
- Will the information gained from this study change my management?
- Will the information gained be worth the pain, expense, inconvenience, etc.?

Remember that patient reassurance about your diagnostic conclusions is a reasonable justification for a diagnostic study. However, don't get studies just to fill up the chart, and don't let ordering labs and x-rays be a substitute for thinking. Generally, by the time you order tests, you should be able to anticipate the probable results of those tests.

5. Acknowledge your patient's intelligence

Spend the extra minutes it takes to explain your diagnosis and how you arrived at that diagnosis. Tell your patients what you are going to do to treat what you think they have and *why*. Make sure that you have addressed the questions and concerns that the patient came in with before you end the visit. When given the right information, your patients will think about their healthcare in a rational manner. Patients will be more accepting of your diagnoses and treatments (or lack of treatments) when they know how and why you arrived at those decisions. A few minutes invested in such explanations can go a long way toward changing your patients' attitudes from passive acceptance to active participation in their healthcare.

6. Give your patient stewardship

Tell your patients when to come back. They should know before they leave that you *want* to see them if the predicted course of their illness or wellness does not occur within a desired or predicted time frame. Before they leave your office or clinic, your

patients should know what potential adverse outcomes to look for and within what time frame. Communicate clearly to them that you want to see them if any adverse events occur. Let your patients know that you don't know everything, that may be wrong, and that you don't have a crystal ball. This is why you need your patient and/or their family members to be part of the healthcare team. They are your eyes and ears when you can't be at their side.

This little exercise accomplishes three important things:

- For timid patients, you communicate that they haven't used up their one allotted visit for this illness.
- You communicate that your goal is for them to be *well*, not for them to get *out of your clinic*.
- It minimizes your liability because: (1) the patient himself and/or family members go home with specific instructions on what to watch for and when to return for additional care. This minimizes your likelihood of a bad outcome. If there is no bad outcome, there is no lawsuit. (2) People are less likely to sue those who effectively communicate genuine caring.

7. Put away your hammer

Hammers can be very useful tools, but they can also be dangerous weapons. Too often, patients bring in complaints or concerns that don't fit nicely into our "comfort zone." Lack of experience or expertise in certain areas, uncomfortable emotional feelings associated with some possible diagnoses, and the inconvenience or extra time required for certain evaluations all can contribute to a lack of willingness to consider problematic or less familiar diagnoses. So, we get out our hammers and we tap (or pound) away at the patient's signs, symptoms, complaints, and concerns, trying to make that square peg fit into the round hole of our comfort zone. Then we buff and trim the chart so it "spins" the tale to look like a diagnosis with which we are comfortable, and send the patient on his or her way. Over time, this sort of hammer use can drive a wedge between you and your patients. It can also sculpt a huge threat to your patient and to yourself.

Conclusion

Put away your hammers. Cultivate caring. Open your ears to listen. Take

your hands out of your pockets and off the keyboard to touch your patients. Order all the studies that you and your patient need (but only the studies that you need). Acknowledge that your patients can understand your reasoning if given the chance. Give them stewardship for their health, telling them when and why to come back. In these days of managed care, dwindling resources, and doing more with less, wouldn't it be nice to have some extra help in your practice? With only a little extra initial effort but no additional financial investment, you can get home health observers, a great PR person, and a loyal, repeat customer all rolled into one—your patient! □

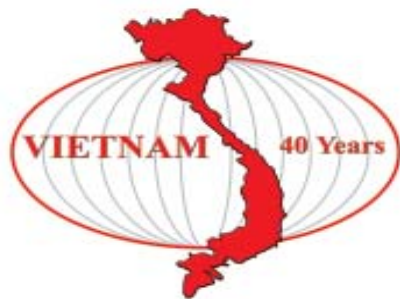
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CORRECTION

CDR Frank, Director, Joint Medical Executive Skills Institute (JMESI) contributed significantly to the previously published article *Executive Medicine Career Plans* (Jan-Feb 2004) and the original authors would like to take this opportunity to properly credit her for the oversight. The mission of JMESI is to bring together differing service perspectives with a variety of healthcare experiences and skill sets to effectively implement the Joint Medical Executive Skills Program by providing military healthcare leaders the tools and resources they need in their roles and missions. The direct impact of her contribution to this program will be felt for many years to come.



I Knew I Was in a War

Forty years ago, an incident in the Gulf of Tonkin turned a festering conflict in South-east Asia into a full-blown war. On 2 August 1964, USS Maddox (DD-731), was on what was said to be a routine patrol in international waters when three North Vietnamese torpedo boats commenced a high speed torpedo run on the destroyer. What happened that day and shortly thereafter resulted in the “Gulf of Tonkin Resolution,” which gave the president the power “to take all necessary measures to repel any armed attack against the forces of the United States and to prevent further aggression.” Escalation of the war in Vietnam was now assured.

LT Samuel Halpern, MC, USNR, had been raised on a farm in Kentucky’s bluegrass region, before attending medical school at the University of Louisville. He joined the Navy in 1963, the year a coup in South Vietnam overthrew the Ngo Dinh Diem regime. “When I went into the Navy, suddenly I was an officer and a gentleman by an act of Congress. People saluted me. And they stuck my pockets full of money. I just couldn’t believe it. When you’ve been a sharecropper for the first 14 years of your life, security means something.” Soon placed in harm’s way as medical officer of Destroyer Division 192, that sense of security quickly evaporated.

There were four ships in my division, the *Berkeley* [DDG-15], the *Maddox* [DD-731], the *Picking* [DD-685], and the *Herbert J. Thomas* [DD-833], which kept breaking down and didn’t go to WESTPAC with us. We were in port and I was told that the commodore [John J. Herrick] wanted me to board the *Maddox* immediately. Nobody told me what I was going to do or where we were going but I was told to get the medical department in tiptop shape.

I didn’t know anything at all when I went aboard the *Maddox*. I didn’t even know how to salute. When I walked aboard I saluted everything in

sight until finally I began to catch on as to what I was supposed to do. But I had luck. On destroyers, you have what they call independent duty corpsmen. These are guys who have been in the Navy for a long time, are highly trained, and are very good at their trade. They are easily as good as physician assistants and they also know the Navy. These guys would tell me what to do.

Maddox was a pretty scarred up old veteran, a 2,250-ton destroyer that had seen a lot of action during the Second World War. You could see the places where the kamikazes had hit the ship and where that damage had been repaired. Besides the punish-

ment she had undergone then, *Maddox* had also fired a lot of shells in Korea.

As I went over the brow, slightly to the right I saw a twin 5-inch 38 mount. You could go up the deck on either side or through the passage-ways from there. Aft were racks with depth charges, spaces with ammunition, and the loading gear for the 5-inch 38s. Along both sides of the ship were 3-inch guns and torpedo tubes. As I went all the way forward I came upon Mount 51, and behind and above it was Mount 52. Both were twin 5-inch 38s.

The bridge was behind and above the second turret. The wardroom was

forward and officers' country was amidships. All the way forward was chiefs' country. Crew's quarters was aft. CIC [combat information center] was in the middle of the ship.

The sick bay was about 5 feet by 4 feet. It had a cabinet containing all the pharmaceuticals—antibiotics, morphine, compazine, and anything I might need. The nice thing about going to sea on a man of war was that everybody was young. If they weren't in good shape they wouldn't be there.

During combat, the wardroom table would become my operating theater, and there were surgical lights above the table. We had all sorts of supplies stuffed beneath the divan in the wardroom with lots of IV fluids, injectable anesthetics, and ether. I know what you're thinking. Ether is explosive! I know it is but we needed some way of putting patients to sleep. If you were hit aboard a man of war, you generally weren't going to have just one casualty. We had some 260 people aboard the *Maddox* packed in an area some 300 feet long and about 30 feet in the beam. If there was going to be combat, there would be a land office business. We were going to take care of people in the triage method. We would stanch the hemorrhage and keep the men alive as best we could until we could off-load them. And, of course, the crew hoped the doctor and the corpsman were not dead. Both of us would be in that wardroom so if we got wiped out, the crewmen would be on their own.

From the start, nobody told me a damn thing. They kept me in the total dark. I didn't know what was happening. I knew we were heading toward Taiwan. We pulled into Keelung [Taiwan], where they brought some

Marines aboard led by a captain who was in charge of an eavesdropping device which was set up on the deck of the *Maddox*. There was a circle drawn around it and the Marine guards. There was no question that if you got inside that circle, they would shoot you. These were mean-looking and very scary people.

We then took off. I wasn't totally stupid as to what was going on. I knew the only thing in the direction we were going was Vietnam.

The first time I knew we were at war was one morning when I woke up just at the crack of dawn and went out on deck. I liked doing that because the South China Sea has wonderful things to see in August. It's still cool at that hour. The waters are in the doldrums so it's flat and you have magnificent sunrises and sunsets. I could see some specks off in the distance, and they were moving faster than anything I'd ever seen on water. There were three boats and I didn't know what the hell they were. I found out later they were PT boats. But I figured that nothing could move that fast unless it was a PT boat. And they were really hauling. I figured there had been some action and found out later that they had just raided North Vietnamese facilities.*

When we joined Task Force 77—the *Ticonderoga* [CV-14] and a lot of other ships—I learned we were a DeSoto or intelligence patrol. But I didn't know what we were trying to become intelligent about.

After resupplying and refueling, we headed into the Gulf of Tonkin.

*These were South Vietnamese PT boats on their way back from raiding North Vietnamese facilities.

We slowed down to a very slow 5 knots. At 5 knots you can go a hell of a long way on a tin can because you're hardly burning any fuel. It was hot. It was so hot! Unbelievable. We were surrounded by junks. Everywhere you looked there were junks, supposedly fishing vessels with nets out. We tried to avoid them but we had guns at the ready. I think we were at Condition 3, one condition before general quarters, and I believe half the guns were manned at the time. A tin can of that age had four boilers, and we had 1 and 2 boilers on the line and were just kind of lazing along. Nothing really was happening.

The day of the first attack [2 August], I was lying in my bunk when we went to general quarters. I wondered why but I knew something was happening even before we went to general quarters. If you have been aboard a destroyer for some time, you could listen and tell the speed of the ship, where the seas were coming from, how many boilers were on line—the whole thing. And I was pretty good at deciphering what was going on down in the fire rooms.

We began picking up speed. The captain, Herb Osier, came on the 1MC and said we were being approached by North Vietnamese PT boats and we had information that they intended to engage us. If they closed to 10,000 yards, we were going to fire warning shots. If they got closer than that, there would probably be an engagement, or something to that effect.

I went to my GQ station in the wardroom and Chief Aguilar and I set up the hospital there as best we could. We got out some mattresses and threw them on the floor for casualties. We secured all the stuff we

could in case we took a hit, which was ridiculous because if we took a hit . . . The *Maddox* had the watertight integrity of a sieve. She was just an old rust bucket. Nevertheless, we were ready.

When we let go with the 5-inch 38 warning shots, I thought that was it. We were really speeding up and I could tell we were bringing other boilers on line. The generators were whining like mad and we were doing somewhere between 25 and 28 knots. We could probably do about 31 knots in absolutely calm seas before we shook apart with all four boilers on line.

All of a sudden I heard, "Torpedo in the water! Torpedo in the water!" The 1MC was wide open. I thought, "This ain't real!" I didn't know anything about combat at sea. Aguilar kept yelling for me to get up and grab the big I-beams in the overhead and get off the deck. I didn't understand why he wanted me to do that. He looked like an idiot to me grabbing those beams and lifting himself up on his tiptoes. I found out later why. If you're standing and the ship takes an explosion under you, it will break both your legs as the ship suddenly lifts up. I finally did what he said.

Our 5-inch mounts were just wide open—Boom! Boom! Boom! Boom! Boom! We were firing everything we could. And then I heard Crack! Crack! Crack! That was the sound of the 3-inch mounts. Our 5-inch guns had a range of about 10,000 yards. The 3-inch guns had a range of about 6,000 yards. That meant that if we were opening with the 3-inch mounts our attackers had to be within 6,000 yards of us and were going to be on us real quick. We were throwing ev-

erything in the world at them. Some of the shells were even star shells. The only use these have is to light up the night. You're not going to hurt anything with a star shell unless the shell actually hits the target. And then I heard "Torpedo in the water! Torpedo in the water!" again followed by "Torpedo is past us." They were maneuvering the ship and the torpedoes were missing us.

I don't know how long the fight went on—not very long—and then it broke off. The planes from the *Ticonderoga* then came in and hit the three PT boats. At the time, I was told we had sunk one, one was dead in the water, and the other limped off.

We had taken hits with some .50 caliber stuff. One of them hit the after mount. Chief Keith Bain, the after mount director, was in there and a bullet bounced all around him in that confined, little space but missed him. Anyway, we got out without any casualties but for some ruptured eardrums from the concussion of our own guns.

The men who were on the main deck didn't get cotton, or whatever we used back then, into their ears in time. If you are on deck and someone fires a 3-inch shell, it is absolutely painful. Your eardrums are splitting because it's a high-pitched crack. If a 5-inch shell is a muffled baritone, a 3-inch shell is a tenor. Everybody I examined that day who had a headache or an earache had blood behind the eardrum—in both ears. By then I knew I was in a war. Someone was trying to kill me and I knew that we had killed somebody.

We left the Gulf of Tonkin and rendezvoused with Task Force 77. Then we were ordered back into the Gulf,

this time accompanied by the USS *Turner Joy* [DD-951].

I prepared for major casualties. I had all I could use to stop severe bleeding, to insert endotracheal tubes, to stop pain. I also had IV fluids, which I hung so that if it sloshed around, it wouldn't be smashed. There's a real problem. That destroyer rolled 10 degrees from the vertical **in** port. And when you're at sea bogeying along, you're not only going to roll but pitch and yaw.

If you're going to use an anesthetic, you can't use a spinal because it will creep and the guy will stop breathing. If it's a severe injury, you're going to have to use ether. Then if anybody sets off a spark, you're going to blow hell out of the ship and kill everybody—yourself and the patient, too. We also had xylocaine, but the best anesthetic was going to be morphine. You hit a guy with 10mg of morphine IV, give him another 10mg IM [intramuscular] and he's going to calm down.

So we set up to triage as best we could. Aguilar and I had rehearsed this many times and we knew what we were doing. And then we just waited.

The worst part of combat was to be idle. During the attack, idleness is the worst thing that can possibly happen to you. You want to be doing something. You want to be watching the dial in the engine room. The best thing to be doing is firing a gun. You're going to slam those shells in, just shoot hell out of them, and this gives you a feeling of comfort. But when you've got nothing to do, that's like an execution. You keep waiting to die. Everything is out of your hands and somebody else is fighting your battle for you.

The night attack occurred on the 4th of August. I had gone to CIC earlier in the day and saw things on the radarscope indicating that we were surrounded. Whether it was weather or not I couldn't tell. I was not a CIC officer. I wouldn't have known a hard target from a soft target. But there were things everywhere and they seemed to be surrounding us. I thought this didn't look too good, especially with the *Turner Joy* right behind us. We were scared to death of the *Turner Joy*. We didn't know how much combat experience the ship had. A misplaced 5-inch shell was not going to do an old tin can like ours very much good if it hit us amidships. In battle, you've got to know where everybody is. If you don't, you are going to sink each other.

The *Turner Joy* was right in our wake. Time went on and then we started picking up speed and zig zagging. It wasn't very long after that that we went to general quarters and the captain said we were being attacked. I heard a 5-inch mount go off. I thought, "Okay, this is it." Then, all of a sudden, I heard, "Torpedo in the water! Torpedo in the water!" And that began the wildest damn time you have ever seen in your life.

We were zig zagging. We were firing. I could hear talking on the bridge because the 1MC was open down in the wardroom. I heard the commodore say, "Shoot 'em. Shoot the sons of bitches!" I talked to Bain later and he said that he would see a target and then it would disappear. He'd be fixed on it and ready to shoot and then it would vanish.

Meanwhile, we were being thrown all over the place in rough waters on the blackest of damn nights I'd ever

seen. The *Turner Joy* was opening up and it was scary. I kept hoping somebody was not making a mistake. Anyway, we kept getting torpedo sightings. The sonar man was listening for high-pitched screws and doing the best job he could. I'll guarantee it because his ass was on the line. He's not going to be court martialed; he's going to be dead if he's wrong. He kept hearing those sounds and had an option. He could either call them what he thought—a torpedo—or he could take a chance that it wasn't a torpedo and he was wrong. I would have done the same thing the kid did, namely tell the bridge there was a torpedo in the water.

So, we were zig zagging all over hell and every now and then we would open up with a one—or two-shot volley. I could also hear the thud of the *Turner Joy* out there. This went on—the zig zagging and "Torpedo in the water! Torpedo's missed us!"

We had set "Zebra" throughout the ship which meant we were locked down. We had all the boilers on the line in the fire rooms and it got up to 140 degrees. Then the [heat] casualties started coming into the wardroom and I did exactly what I was supposed to do. I jammed IV fluids into them, wet them down, and got them back into the fire rooms as quickly as I could. Of course, they came back after about 10 minutes. The second time they would be sicker and I'd do the same thing again and send them back. I hated to do it. The only time I decided not to send them back was when I thought they wouldn't survive the next time down. If I thought they'd die, I'd keep them.

People were lying all over the wardroom floor and I was stepping

over them. Some had collapsed veins yet I tried to jam 18-gauge needles into collapsed veins. It was amazing! It really helps to have something to do in combat, and I was so damned busy. I'd hear the reports of torpedo in the water but I didn't give a damn. I had something to do. There wasn't anything I could do about the torpedo but I could do something about the guy lying there. And that's what I did. Those kids didn't realize that they did more for me than I did for them.

Eventually, the skipper came on the 1MC and said he thought the sounds the sonar man was picking up was the sound of our rudder as we moved through the water, and we were breaking off action. We slowed to about 20 knots, and the *Turner Joy* did likewise. Of course, everyone was waiting to see what would happen.

Finally, I got all the guys cleared out of the wardroom, and when we secured from GQ, I could not believe what I saw. All the officers came into the wardroom laughing hysterically. It was absolute pandemonium. It was one of the wildest scenes I had ever experienced. They didn't know what the hell happened but they had survived. The skipper, COMO Herrick, and some of the old chiefs had seen combat during the Second World War but the rest of us had never heard a shot fired in anger. Everybody was laughing. I didn't realize I was laughing but suddenly I discovered that I was laughing too.

That ended the action. Jim Stockdale was our CAP [Combat Air Patrol] that night flying a lone F-8. He was it. He was up there and kept looking for targets but couldn't find any. That's what he told me later when we

discussed the whole thing. There wasn't anything there he could see and maintains to this day that he never saw anything.* The commodore later told me that perhaps three of these torpedoes were real. I don't know what Osier thought.

Anyway, we left the Gulf of Tonkin and rendezvoused with Task Force 77 and the next day the captain, the commodore, the XO, and Mr. Bueler got in the motor whaleboat and went over to the carrier. When they came back they were very somber. Something really big was happening. And they were wearing sidearms. It wasn't more than a few hours later that every officer was wearing a sidearm and everyone was really grim. So, I asked for a sidearm and was refused. They said I was a noncombatant. I kept wondering whether they realized my situation. Maybe I was a noncombatant but not to the Vietnamese.

We went back into the Gulf—the *Turner Joy* and us. We began lolling around there and not going very fast. I kept waiting for something to happen. It was very tense. A Navy lieutenant kept running up to the bridge and monitoring everything the Vietnamese said. We had broken their code. Late one night I was sleeping and the staff ops officer came in, shook me, and said, "Doc, put your clothes on. The commodore wants to

see you in his cabin." It was about 2 o'clock in the morning.

When I entered, the commodore looked awful. Herrick was worried that this thing was going to spread into a giant Asian war. He smelled a rat as to what was going on. How much of the rat I never realized until I'd had time to reflect on what was going on. Herrick had a headache and I gave him something for it. He said, "Doc, I want you to get out all the morphine and distribute a syrette to every man. We're gonna get hit tomorrow." That kind of got my attention.

Aguilar got out the morphine and we distributed a syrette to everybody. By this time I was a fatalist. I wanted a weapon. I felt that I had a right to defend myself. I did not want to become a prisoner of war. My family was slaughtered in Europe during the Second World War. We lost a whole bunch of people in the concentration camps and I just wasn't able to cope with the idea of dying that way. If I went in the water, I wasn't going to leave the Gulf alive. I knew that because I wasn't going to rot in prison camp. But I never got the sidearm and I was a farm boy and a better shot than 90 percent of the guys out there. Anyway, we were sitting there waiting for the attack that was supposed to come. And waiting . . . and waiting . . . and waiting. Then the staff ops

officer came to me and said, "Relax, Doc. The attack's been called off." So I guess what happened was the Navy lieutenant operating the eavesdropping gear heard the enemy wasn't going to attack.

No more attacks occurred after that and we left the Gulf and rejoined Task Force 77. We then went back to Subic.

As you know, after that second attack the president addressed Congress and asked for the Tonkin Gulf Resolution. Twenty years later I learned that the bullet that had hit the after mount director in the first attack was presented to Congress as having hit the ship during the night attack. That would have been a profound lie. We told the truth. Anything that happened afterward was done by the Administration or the military. But I can tell you this. Anything that went off that ship that night and the next day was gospel. Nobody lied about anything. Whether or not there were ships out there that fired torpedoes at us, I don't know. But I know that what was reported to the Administration was the truth. And how they dressed it up I don't know, but I can tell you that that bullet did not come from the night attack. Nothing hit us during that night attack, nothing at all.—JKH □

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*James B. Stockdale was shot down and spent the rest of the war as a POW. He was the senior naval officer at the "Hanoi Hilton."

Book Review

A War Of Nerves: Soldiers and Psychiatrists in the Twentieth Century by Ben Shephard. Harvard University Press, Cambridge, MA. 487 pages. 2001.

At over 400 pages, *A War of Nerves: Soldiers and Psychologists in the Twentieth Century*, seems daunting, and in large part remains so. This is due to the immense amount of information presented to the reader. However, just because it's not a fast read does not mean it is not fascinating.

Ben Shephard inundates the reader with statistics, military jargon, and, seemingly, terms unique only to psychology. Yet, it is this information that makes his book so appealing. Although he never "dumbs down" content, the material remains approachable even by those who have never set foot in a psychology class (the reviewer speaks from experience).

A War of Nerves is an in-depth look at the ever-changing relationship between psychology and the military in the 20th century (focusing mainly on the United States and Britain). Beginning with World War I and the coining of the term "shell shock," through Vietnam and the birth of a new term for the same malady—Post Traumatic Stress Disorder—Shephard explores the ebb and flow of psychiatric involvement, diagnosis, and treatment of military personnel.

In today's age that stresses mental health, therapy, and self-awareness, it is difficult to remember that in 1914 psychology/psychiatry were relatively new fields and that treatment was not offered to or sought by the general public. As a journalist, Shephard is careful to keep this in mind and submits very little judgment regarding what was then accepted practices and treatments.

One of the key issues facing military psychiatry, beginning in World War I and continuing to the present, is the military's demand to have a ready fighting force and the psychiatrist's need to treat his patients. Early during World War I, it became apparent that individuals, although somewhat distant from exploding shells, could suffer "shell shock." Often the resulting pent up anxiety was enough to cause psychological problems. However, two of the leading physicians on the front lines disagreed about treatment. Gordon Holmes believed that as long as he cured physical manifestations, such as strange gaits or inability to speak, a soldier was ready to return to the front. On the other hand, Charles

Myers, believed that true cures came through discovery of underlying psychological causes. He "insisted that the therapeutic needs of the individual be addressed." Unfortunately, this conflicted with military leaders' wishes to have as many available men able to fight as possible. Many soldiers were simply given a few days' rest and then sent back to their units. Shephard makes it clear, though, that many men used "shell shock" as an excuse to go the rear. Psychiatrists walked a fine line in deciding who was truly traumatized and who was simply trying to shirk their duty, a difficult task even today.

During World War II it became apparent to many military psychiatrists that men were less prone to mental breakdown if they remained with the same unit or group. This had been noted in World War I, but became even clearer during World War II, especially with U.S. forces. If a soldier was wounded, another man was available to take his place on the front almost immediately. However, the new soldier likely would be fighting alongside men he barely knew.

During World War II, it also became clear to psychiatrists that the risk of psychiatric trouble increased greatly as time in combat increased. Giving soldiers periodic leave, or even just rest, was one component of maintaining a healthy fighting force.

This philosophy of limited fighting time is what led to the 1-year tour of duty in Vietnam. Unfortunately, 1-year tours undermined the principle of group cohesion within fighting units. Toward the end of tours, men often became anxious about insuring their own safety at the expense of other members of their units. The unit cohesion lesson, learned at great expense during World War II, was sadly forgotten.

Shephard makes the relevance of military psychiatry clear. Questions such as, "Can science provide ways to manage or control fear?" are still important today. His book is well researched, and by including actual patients and psychiatrists' struggles, he adds relevance and human interest to what would normally be a very dry subject.

—Ms. Tronic is a summer intern, Bureau of Medicine and Surgery (M00H), Washington, DC, and a graduate student at Simmons College, Boston, MA.

Navy Medicine 1985



Photo by HMM3 Timothy Kelley, NSHS, Bethesda, MD.

President Ronald Reagan thanks the staff of NNMC Bethesda following surgery at the hospital.